Chorionic Gonadotropin

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Criteria for Approval (all of the following criteria must be met):

- ❑ Patient is male.
- ❑ Diagnosis of one of the following (please check):
  - ❍ Prepubertal cryptorchidism
  - ❍ Hypogonadism secondary to a pituitary deficiency
  - ❍ Hypospadias
  - ❍ Cryptorchidism
  - ❍ Kaposi's sarcoma
- ❑ Patient does not have precocious puberty, prostatic carcinoma, or other androgen dependent neoplasm.

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Note:

- ❖ Not covered for the promotion of fertility.
- ❖ Not covered for the treatment of sexual dysfunction.
- ❖ Not covered for any off-label indication, including weight loss.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date